Assisted Outpatient Treatment: A Summary of the Evidence

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What Is Assisted Outpatient Treatment?

Assisted Outpatient Treatment (AOT), also known as Involuntary Outpatient Commitment (IOC), is a civil court procedure in which a judge orders an adult with a serious mental illness to adhere to community-based treatment. As of 2024, 48 states and the District of Columbia authorize some form of AOT. Implementation varies widely across and within states in eligibility criteria, duration of court orders, available services, and enforcement mechanisms.

AOT typically involves mandated medication (often long-acting injectables), required attendance at outpatient appointments, substance use restrictions, and case management monitoring. Noncompliance may result in law enforcement transport to a hospital for evaluation, and potentially involuntary hospitalization or medication over objection. Court orders are typically 90–180 days, renewable indefinitely in most states.

What Do the Randomized Controlled Trials Show?

Three randomized controlled trials (RCTs) of involuntary outpatient commitment have been conducted worldwide. RCTs are the gold standard for determining whether an intervention causes better outcomes, because random assignment controls for all other factors that might explain differences between groups.

	Duke / North Carolina (Swartz et al. 1999, 2000, 2001, 2002)	Bellevue / New York City (Steadman et al. 2001)	OCTET / England & Wales (Burns et al. 2013, 2015)
Hospital readmissions	Not significant	Not significant (51% vs. 42%)	Not significant (12 or 36 months)
Violence	Not significant (overall comparison)	Not significant (no violent crimes either group)	Not measured
Arrests	Not significant	Not significant (18% vs. 16%)	Not measured
Functioning / Quality of life	Not measured	Not significant	Not significant
Perceived coercion	SIGNIFICANT: 45% higher in IOC group (Swartz et al. 2002)	Not significant (but ~50% of both groups reported high coercion)	Not significant

Key findings: None of the three RCTs found statistically significant differences between court-ordered and control groups on any primary clinical outcome. The Duke study reported positive results only in secondary, post-hoc subgroup analyses — specifically, for individuals whose court orders were sustained for 6+ months and who also received intensive services (3+ contacts/month). However, commitment duration was not randomly assigned, and the Cochrane Collaboration, which sets international standards for evidence-based review, treats post-hoc subgroup findings that contradict null primary analyses as having low evidentiary value.

The most recent ('Gold Standard') Cochrane meta-analysis (Kisely & Campbell, 2017), pooling all three RCTs, found no significant effect of court-ordered treatment on any of the meta-analyzable clinical outcomes studied with the exception of low quality evidence for reduced victimization. The number needed to treat (NNT) to prevent one hospital readmission was calculated as 142 — meaning 142 individuals would need to be placed under court orders to prevent a single hospitalization. While AOT is typically justified as a means of addressing "violence" or "social harm" in the US, recent meta-analysis of all available research on the effects of involuntary outpatient treatment on aggression or criminal offending found no significant benefits in either primary or sub-group analyses (Kisely et al., 2025).

Notably, in the Duke study, besides reduced victimization, coercion was the only other variable that reached statistical significance in a primary between-group comparisons: individuals under court orders reported 45% higher coercion than controls who received the same services without a court order. Black participants were approximately twice as likely to

experience high levels of coercion as white participants, and disproportionality remained even after controlling for diagnosis, symptom severity, substance abuse, insight, functioning, marital status, and the length of the court order (Swartz et al. 2002).

What About Non-Experimental Studies?

Since the Duke and Bellevue RCTs, no further randomized trials of AOT have been conducted in the United States. The post-2001 evidence base consists of pre-post (mirror-image) studies, quasi-experimental matched comparison research, and the 2024 federal ASPE evaluation. These studies generally report improvements in hospitalizations and service utilization after AOT enrollment. However, they share fundamental limitations:

- **Regression to the mean.** Individuals are enrolled in AOT at their worst point — after repeated hospitalizations or crises. Statistical improvement from that low point is expected regardless of intervention. Only comparison to a control group can account for this, and non-experimental studies lack true control groups. Studies of voluntary ACT as well as studies comparing ACT and AOT (as is true of the ASPE evaluation) find decreases in all areas for individuals receiving voluntary ACT, not just AOT.
- **Confounding of court orders with enhanced services.** AOT enrollment typically comes with priority access to assertive community treatment (ACT) or intensive case management, linkage to SSI/SSDI and other social welfare benefits and sometimes guaranteed access to supportive housing. When hospitalizations or arrests decrease after someone begins receiving ACT and/or supported housing, attributing that improvement to the court order rather than the services is not justified.
- **Provider accountability confound.** AOT creates mandated accountability for providers to deliver services. This monitoring and accountability effect may itself drive improved service delivery, independent of the legal coercion experienced by the individual.
- **Insufficient quantitative measurement of harm (**see also below and cf Kisely et al., 2024 meta-analysis of what has and has not been documented to date globally**).**

The largest non-experimental study is the original New York State Kendra's Law evaluation (Gilbert et al., 2010; Swartz et al. 2010), which analyzed Medicaid claims for 3,576 AOT recipients. The pre-post analyses showed reduced hospitalizations and increased service utilization. A contemporary New York-based quasi experimental study (Phelan et al. 2010) found some positive benefits, albeit with uncertain service utilization and provider accountability differences between AOT recipients and matched (quasi-experimental controls) but found no significant differences in psychotic symptoms or quality of life. The authors concluded that results "should be interpreted in terms of the overall impact of outpatient commitment, not of legal coercion per se." Researchers at the University of Pittsburgh and Human Services Research Institute have recently completed a second, state-sponsored evaluation of Kendra's Law – report will be released in early summer 2026.

ASPE Federal Evaluation and GAO Assessment

In 2024, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) published a federally funded evaluation of SAMHSA's AOT Grant Program, conducted by RTI International, Policy Research Associates (PRA), and Duke University School of Medicine. The evaluation examined 6 case study sites selected from 18 federally funded programs and used within-group pre-post analyses supplemented by a between-group comparison at a single site. Most measures were collected through structured interviews with AOT recipients conducted by clinicians working at their sites, creating potentially far-reaching measurement bias as participants already under court orders and motivated to appear "compliant" and "happy" in order to discharge their orders would generally not be expected to honestly report concerns and negative outcomes directly to clinicians with (plausible) power over future decisions to renew.

In July 2025, the U.S. Government Accountability Office (GAO) reviewed the ASPE evaluation and SAMHSA's outcome reports and concluded:

"HHS's assessments of the effects of the AOT grant program were inconclusive. This is because the ASPE and SAMHSA assessment efforts were both hampered by methodological challenges, many of which were inherent in the program and beyond their control."

The GAO declined to report the specific results of either the ASPE evaluation or SAMHSA's reports to Congress, stating that they "decided not to include the evaluation's results because (1) we determined that ASPE and RTI International lacked information needed to help understand the extent to which the results represented all AOT participants included in SAMHSA's grant program; and (2) our analysis of information we received from RTI International showed a high level of uncertainty for some of the results."

Since 2016, the federal government has awarded approximately $146 million in AOT grants to 63 grantees across 28 states. The GAO concluded that "challenges assessing the grant program are likely to persist."

Coercion and Potential Harms

Although AOT's defining feature is legal coercion, remarkably few studies have measured the experience or consequences of that coercion. The available evidence includes:

- **The Duke North Carolina study (Swartz et al. 2002)** found that court-ordered treatment increased perceived coercion by 45% compared to controls receiving the same services. Each additional month under a court order increased the risk of high perceived coercion by approximately 10%. African American race independently predicted nearly twice the odds of experiencing high coercion (OR=1.89), after controlling for all measured clinical and demographic variables.
- **Munetz et al. (2014)** compared 17 former AOT participants to 35 mental health court graduates in Ohio. AOT recipients reported significantly higher perceived coercion on every dimension measured compared to mental health court participants, significantly lower procedural justice in interactions with judges, significantly less respect after program completion, and significantly less hope after completion than before.
- **The judicial process itself raises substantial procedural justice concerns**. A qualitative study of 13 NYC judges and 20 attorneys (Player 2015) found that judges overwhelmingly defer to the single evaluating psychiatrist, apply the evidence standard loosely, and rarely credit testimony from the individual subject to the order. Defense attorneys reported that their clients' testimony often "means nothing" in practice and that psychiatric evaluations are typically 15–60 minutes conducted by clinicians with no prior treatment relationship.

Additional areas of potential harm that have not been published in the US AOT context include:

- **Serious medication side effects from mandated polypharmacy, often without adequate access to treatment or intervention (beyond screening),** including metabolic syndrome, Type II diabetes, antipsychotic-induced Parkinsonism, and cognitive decline secondary to the anticholinergic effects of prescribed medications
- **Custodial iatrogenesis**: institutionalization in the community through supervised residential facilities that control finances, food, and social life creating dependency and de facto social and physical segregation
- **Disruption of family bonds including custody, elder caregiving and reproductive justice concerns** – AOT orders may separate parents from children, and children from elderly parents, require residence in facilities that custodial parents have described as "too terrifying to expose a young child too" and/or that are physically distant; reproductive justice concerns include medication side effects impacting fertility, pregnancy and potential iatrogenic effects on the developing fetus
- **Social defeat** — the chronic experience of subordination and powerlessness that is itself implicated in the development and worsening of psychosis.

These harms are non-trivial and publications in preparation (Pitt PathLab team) are beginning to document and substantiate how profoundly impactful they can be.

The Central Policy Question

The policy question underlying AOT is not "do people improve after AOT enrollment?" — pre-post studies can answer that question affirmatively for virtually any enhanced service, including voluntary ACT, supported housing, and SSI/SSDI access. The relevant question is: **does the court order produce better outcomes than the same services delivered voluntarily?**

The three randomized controlled trials that were designed to answer this question all found null primary results. The Cochrane meta-analysis confirmed no significant effect based on the pooling and re-analysis of data across RCTs. The most

recent federal (ASPE) evaluation was deemed "inconclusive" by the US General Accountability Office upon audit and independent analysis of evaluation data. Meanwhile, the one participant-centered outcome measured in the Duke RCT—perceived coercion — is significantly increased by AOT, disproportionately for Black individuals, and the international qualitative research confirms widespread experiences and negative impacts of coercion within AOT (Barti et al., 2022; Goulet et al., 2020). Meanwhile, Intensive voluntary services such as ACT and Housing First have a well-established evidence base for improving outcomes for individuals with serious mental illness. Policymakers considering AOT should weigh whether the documented costs of legal coercion, in combination with serious ethical concerns, are justified given the absence of evidence that court orders add benefit beyond what these voluntary services achieve.

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For questions please contact Dr. Nev Jones, University of Pittsburgh – nevjones@pitt.edu